Correspondence

The Editorial Board will be pleased to receive and consider for publication correspondence containing information of interest to physicians or commenting on issues of the day. Letters ordinarily should not exceed 600 words, and must be typewritten, double-spaced and submitted in duplicate (the original typescript and one copy). Authors will be given an opportunity to review any substantial editing or abridgement before publication.

Nonfluoridated Water Used in Manufacture of Infant Formulas

TO THE EDITOR: We recently read the article "Preventable Dental Disease" by Peter Rank and co-workers in the October 1983 issue.[1] We are concerned that readers may be misinformed by the statement "the increasing use of infant formulas with high fluoride content . . . ," and we wish to provide additional information on this subject.

The Infant Formula Council represents the manufacturers of infant formula in the United States. Member companies voluntarily decided in 1979 to manufacture infant formulas with nonfluoridated water based on recommendations of the American Academy of Pediatrics Committee on Nutrition.[2] Before 1979 there were various levels of fluoride in different infant formulas on the market, depending on whether they were manufactured with fluoridated or nonfluoridated water. Since the fluoride content of local water supplies varies considerably, the use of nonfluoridated water in the manufacture of infant formula allows physicians to regulate individually an infant's fluoride intake based on fluoride levels in the community water supply. Physicians can now be certain that infant formulas contain an insignificant quantity of fluoride and can safely be mixed with fluoridated water or given with a dietary fluoride supplement as medically indicated.

ROBERT C. GELARDI
Executive Director
Infant Formula Council
Atlanta

REFERENCES

1. Rank P, Julien JH, Lyman DO: Preventable dental disease (Public Health and Preventive Medicine). West J Med 1983 Oct; 139:545-546
2. American Academy of Pediatrics, Committee on Nutrition: Fluoride Supplementation: Revised Dosage Schedule. Pediatrics 1979 Jan; 63: 150-152

More on Herpes Zoster

TO THE EDITOR: As a practicing anesthesiologist for 40 years, and a specialist in pain management for the past 10 years, I am writing you in regard to the article "Clinical Aspects of Herpes Zoster" published in the November 1983 issue.[1]

Herpes zoster is, in my opinion, the most poorly treated disease in the practice of medicine. Why? Because the medical public, in general, is uninformed about the ideal treatment of herpes zoster pain, the most distressing symptom of this disease. The November article does not help in this regard. The author, Dr Glaser, does not even mention the one treatment that eradicates this pain. He obviously is unaware of it.

Conservative management consisting of corticosteroids, analgesic medication and local application of anesthetic ointment is ineffective in relieving the severe pain of herpes zoster.

Analgesic blocking has proved to be the most efficacious method of managing herpes zoster. Injection of the sympathetic and somatic nerves supplying the region involved, early in the disease—that is, within 30 days of the onset, will do three things: It will give the patient complete pain relief, it will shorten the duration of the illness and the skin eruption by 50% and most important it will prevent postherpetic neuralgia.

Only with this kind of therapy will herpes zoster give up its ranking as the most poorly treated disease in medicine.

Pain is the most important and common symptom in our treatment of human beings. Frank Moya, an internationally known professor of anesthesiology, states that at his Pain Center at the Mount Sinai Medical Center in Miami Beach, one of the largest private practice outpatient pain clinics in the United States, herpetic neuralgia is the second most common and difficult pain problem to treat, surpassed only by back pain.

Throughout the many years that I have been practicing pain management, I have seen innumerable cases illustrating the sad lack of medical information regarding the pain management of herpes zoster. Only by the correction and addition to such articles as "Clinical Aspects of Herpes Zoster" and by publishing more articles regarding the ideal treatment of this disease will we give our patients proper treatment.

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REFERENCE

1. Glaser RB: Clinical aspects of herpes zoster (Topics in Primary Care Medicine). West J Med 1983 Nov; 139:718-720

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TO THE EDITOR: Having recently recovered from herpes zoster and having a personal knowledge of a fairly large number of patients with this disease (mostly pediatric, it is true), I have some difficulty understanding Dr Engel's letter regarding herpes zoster neuralgia in the February issue.[1]

Unless he does a double-blind controlled study, his treatment schedule appears to have no validity. If I